Department of Veterans Affairs **VHA DIRECTIVE 98-033**
Veterans Health Administration
Washington, DC 20420 **July 16, 1998**

TRANSFUSIONS PERFORMED IN OPERATING ROOMS

1. PURPOSE: This Veterans Health Administration (VHA) Directive established policy for the identification process to be used in all VHA operating rooms, (inpatient and ambulatory) prior to the administration of blood or blood products.

2. BACKGROUND: VHA policy has established standard operating procedures (SOPs) to be used when transfusing blood products. These include specific visual verification by two individuals that the unit of blood or the blood product is in fact the one that has been assigned to this particular patient. The Standard Form (SF) 518, Blood or Blood Component Transfusion, documents this process. Nevertheless, there have been rare blood product transfusion related deaths in VHA Operating Rooms (OR) due to patient and/or blood product identification errors. As part of VHA's patient safety policy to provide high quality, safe, appropriate health care, this policy introduces the requirement to perform an additional independent mechanical verification of the identity of the patient and the blood product. This mechanical process utilizes the Veterans Health Information Systems Technology Architecture (VistA) software to read the bar coded identification on the blood product. This will be performed in addition to the current visual verifications. The visual identification by two individuals and this mechanical check will provide an error proof identification process.

3. POLICY: All laboratories in facilities performing surgery must have implemented and use the VistA Blood Bank Package. The identity of each unit of blood and blood products will be entered into the VistA Blood Bank files. At the time the blood product is assigned to an individual, the assignment information must also be entered into the VistA Blood Bank files. Each Veteran Integrated Service Network (VISN) will ensure that all facilities performing surgery have implemented this policy by September 1, 1998.

4. ACTION

a. All patient wristbands will be printed with the bar coded full Social Security Number (SSN) of the patient.

b. All inpatient or ambulatory surgery operating rooms in which procedures are performed which will, on some occasions, require the transfusion of blood products shall be equipped with bar code readers for direct interaction with the VistA Surgical package.

c. When a patient enters the OR, the patient's full SSN bar code on the wristband will be machine read and entered into the VistA Surgical files as a component of the surgical menu options.

d. Should the patient require blood or blood products, two members of the surgical team will visually validate that the blood product is correct for that specific patient. Specifically, they will match the name and SSN on the patient's wristband to the information on the SF 518 and match the information on the blood product to the information on the same SF 518.

THIS VHA DIRECTIVE WILL EXPIRE JULY 16, 2003

e. Upon completing the visual validation, the blood product will then have its identifying bar code mechanical scanned. If the resulting computer message indicates that the database does not have an assignment of this particular unit to this particular patient, a warning message will be displayed indicating that the staff must personally verify that the specific blood product unit is appropriate for this specific patient prior to administration.

5. REFERENCES: None.

6. FOLLOW-UP RESPONSIBILITY: Agatha Francis, Enforcement officer (115) is responsible for the contents of this directive. Questions may be directed to (202) 273-8420.

7. RESCISSION: This VHA Directive expires July 16, 2003.

S/ Thomas Garthwaite, M.D. for
Kenneth W. Kizer, M.D., M.P.H.
Under Secretary for Health

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